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S 000	Initial Comments Facility Reported Incident of December 5, 2024 IL183212 Facility Reported Incident of December 9, 2024 IL183209	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1220 b)3) 300.3210 t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999		

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to protect residents' rights to be free from physical and verbal abuse by R1, and failed to revise residents' care plans following resident to resident physical and verbal

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abuse incidents. These failures affected four residents (R1, R2, R3, R4,) of thirteen reviewed for abuse in the sample of thirteen and resulted in R1 punching R2 in the face with R2 receiving defensive hand wounds requiring medical evaluation at the hospital and prescriptions for oral and topical antibiotic treatments, R1 using verbal expletives towards R3, and R1 kicking R4 in the legs.

Findings include:

The facility Abuse, Prevention, & Prohibition Policy (12/2024) documents: "Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals" and "The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse; corporal punishment and involuntary seclusion." The same policy documents "Instances of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology."

The facility's abuse log (November-December, 2024) documents allegations of R1 physically abusing R2 on 12/7/2024, physically abusing R3 on 12/10/2024, and physically abusing R4 on 12/18/2024.

R1's Resident Assessment (12/13/2024) documents R1 has short-term and long-term

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memory problems, moderately impaired decision making ability, has physical and verbal behavioral symptoms directed towards others placing R1 and others at risk for physical injury, and has wandering behavior significantly intruding on the privacy or activities of others. The same record documents R1 does not have any upper extremity impairment in range of motion and independently uses a wheelchair for mobility.

R1's SBAR Communication Form (12/10/2024) documents: "Resident's confusion and physical aggression has gotten worse. Resident wanders around facility all day, not easy to re-direct, Has had multiple situations where staff have been unable to re-direct. Resident is a high fall risk and frequent faller- Resident is a safety risk for himself and others as he becomes combative towards staff members when they attempt to re-direct." The same record documents R1 was in an altercation with another resident during the previous weekend.

R1's Progress Notes (12/10/2024) document: Resident is experiencing increased confusion and increased behaviors. R1's confusion and physical aggression have worsened. Resident wanders around facility all day, not easy to re-direct, has had multiple situations where staff have been unable to redirect. Resident is a high fall risk and frequent faller and safety risk for self and others as resident becomes combative towards staff members when they attempt to redirect. The same record documents V5 (Registered Nurse) redirected R1 from propelling R1's wheelchair into R6.

The facility's Petition For Involuntary Admission (12/18/2024) documents: "Resident (R1) is demonstrating unprovoked physical aggression

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towards other residents. Threw a glass of water at resident, growls, screams at other residents, grabs at other residents, tries to run others over with wheelchair, kicked another resident in shin. (R1's) behavior provokes confrontation with other residents. When redirected, becomes physically aggressive with staff."

R1's Psychiatric Progress Note (12/22/2024) documents R1 was hospitalized from 12/18/2024-12/29/2024 for agitation and physical aggression towards others and received a 1:1 sitter for safety while hospitalized.

R1's care plan (printed 1/2/2025) documents a 12/16/2024 entry that R1 has a behavioral problem and a goal that R1 will have fewer episodes of behaviors, including wandering into others rooms, and a decrease in behaviors to less than four times a week. The same record does not document any interventions for staff to implement to decrease R1's behaviors.

1. R2's diagnosis list (printed 1/3/2025) documents diagnoses including Dementia without behavioral disturbance.

R2's Resident Assessment (10/24/2024) documents R2 has fully intact cognition, does not have any behavioral symptoms directed towards others, requires moderate to maximal staff assistance to perform activities of daily living, and uses a wheelchair for mobility with moderate staff assistance.

The facility incident report (12/17/2024) documents on 12/7/2024, R1 approached R2 and attempted to remove R2's hat from R2's head in a physical altercation resulting with R2 suffering a laceration and bruising to R2's hand. The same

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record documents both R1 and R2 were transferred to the hospital for evaluation and treatment.

R1's Progress Notes (12/7/2024) document: "Writer made aware of physical altercation between resident (R1) and another resident (R2). Residents separated and investigation began. Resident (R1) states "(R2) had my hat" and (R1) punched (R2) in the face."

R2's Progress Notes (12/7/2024) document R2 stated: "(R1) tried to take my hat and punched me in my face, I am 93 years old and I am still going to defend myself, so I grabbed (R1's) hand to stop (R1) from further punching me and then I punched (R1) to keep (R1) off of me."

R2's hospital report (12/7/2024) documents R1 punched R2 on the face on 12/7/2024 and R2 also sustained skin tears and bruising to R2's hand during the altercation with R1. The same record documents R2 was prescribed oral and topical antibiotic treatment for R2's injuries sustained during the incident with R1.

R2's Orders (printed 1/3/2025) document the following orders: Amoxicillin-Potassium Clavulanate Tablet, 875-125 milligrams, take one tablet by mouth two times a day for skin tears for 10 days (starting on 12/8/2024) and Mupirocin External Ointment 2%, apply to right hand topically three times a day for right hand skin tear for seven days (starting on 12/8/2024).

R2's Progress Notes document the following:

-12/10/2024: Continues on antibiotic therapy related to skin wounds acquired during resident altercation. Right hand remains bruised and

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swollen.

-12/11/2024: Continues on antibiotic therapy related to skin wounds acquired during resident altercation. Right hand remains bruised and swollen.

-12/13/2024: Bruising noted to right hand, resident had previous incident involving another resident which has resulted in this bruising. New order received to monitor bruising.

On 1/3/2025 at 1:00PM, R2 reported R1 has always wandered in and out of resident rooms continuously, and on 12/7/24, R1 approached R2 and tried to take R2's hat off of R2's head, and then R1 punched R2 in the left front cheek area, followed R2 striking R1 back while defending R2's self from further strikes from R1. R2 reported R1 has wandered into R2's room at all times of the day and night, including the middle of the night.

On 1/3/2025 at 2:12PM, V6 (Licensed Practical Nurse) reported separating R1 and R2 during their altercation on 12/7/2024. V6 reported R2's knuckles were bleeding when V6 approached R1 and R2. V6 reported hearing residents frequently say R1 wanders into their rooms and takes things.

R2's care plan (printed 1/3/2025) does not document R1 abused R2 and does not document any subsequent abuse related care planning for R2.

2. R3's diagnosis list (printed 1/3/2025) documents diagnoses including: Major Depressive Disorder, Adjustment Disorder With Depressed Mood, and Insomnia.

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R3's Resident Assessment (12/30/2024) documents R3 has fully intact cognition, does not have any behavioral symptoms directed towards others, requires substantial to maximal staff assistance to perform activities of daily living, and uses a wheelchair for mobility.

The facility incident report (12/17/2024) documents on 12/10/2024, R3 was in the hallway near R5's room and R1 was also present and attempting to enter R5's room. The report documents R3 had asked R1 to not enter R5's room, followed by R1 then calling R3 "bad names" and throwing a cup of water onto R3. The same record documents R5 observed R1 throw water onto R5 in the hallway after R3 had asked R1 to not wander into R5's room.

On 1/3/2025 at 10:07AM, R3 reported R1 wanders continuously throughout the facility in R1's wheelchair, and has wandered in R3's room "one hundred times, I'm not joking." R3 reported R1 stole food, soda, and candy from R3's room last summer, so R3 now has R3's items locked. R3 reported R1 has beaten nurse aide staff and also spit on them. R3 reported observing R1 hit staff hard. R3 reported being scared of R1 because R1 is "so mean."

R3 reported being outside of R5's room on 12/10/2024 and observed R1 wander into R5's room. R3 reported telling R1 at the time to get out of R5's room, followed by R1 throwing a cup of water onto R3, hitting R3 in the torso and legs with the water. R3 reported later in the same day, R1 came all the way inside of R3's room in R1's wheelchair and called R3 a "fat (expletive)" and "ugly." R3 reported facility staff then removed R1 from R3's room after R3 began screaming. R3

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reported R1 has always called R3 names and staff are aware.

R3's care plan (printed 1/3/2025) does not document R1 abused R3 and does not document any subsequent abuse related care planning for R3.

3. R4's diagnosis list (printed 1/3/2025) documents diagnoses including: Cerebral Infarction (stroke), Hemiplegia and Hemiparesis (partial paralysis and weakness on one side of the body), and Generalized Muscle Weakness.

R4's Progress Notes (November-December, 2024) document R4 is blind.

R4's Resident Assessment (12/22/2024) documents R4 has severe cognitive impairment, requires moderate to maximal staff assistance to perform activities of daily living, has upper and lower extremity range of motion impairment, and uses a wheelchair for mobility.

The facility incident report (12/24/2024) documents on 12/18/2024, R1 and R4 were located in the facility living room and V9 (Certified Nurse Aide) overheard R5 and R6 telling R1 to not kick R4. The same report documents written statements made by R5 and R12 of directly observing R1 kicking R4 on 12/18/2024. The report also documents interviews with R8 and R9 who both expressed R1 caused them to feel unsafe living in the facility.

On 1/2/2025 at 2:17PM, V8 (Regional Nurse) reported V9 (Certified Nurse Aide) had reported to her on 12/18/2024 that R4 was seated in R4's wheelchair by the nurse's station when R1 approached R4 in R1's wheelchair and began

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kicking R4 without provocation. V8 reported R1's aggression towards other residents had been increasing.

On 1/3/2025 at 2:38PM, R1 was seated in R1's wheelchair, entered R7's room independently, and began touching R7's personal items. R7 was present in R7's room along with R7's family (unidentified). V10 (R7's medical provider) was also present and discussing medical discharge information with R7 and R7's family. R7's family asked R1 to stop touching R7's personal items. No staff were present or nearby R7's room.

On 1/3/2025 at 3:17PM, V11 (Regional Director of Operations) reported R1 did currently have 1:1 staff supervision, but the staff member providing the supervision had been pulled to work elsewhere leaving R1 unsupervised, therefore, the observation of R1 in another resident's (R7) room was isolated.

R4's care plan (printed 1/3/2025) does not document R1 abused R4 and does not document any subsequent abuse related care planning for R4.

On 1/3/2025 at 3:46PM, R1 was seated in R1's wheelchair and propelling down the hallway. No facility staff were present with R1. R1 then entered R10 and R11's room, where both residents were sleeping. R10 was sleeping in R10's wheelchair located near the doorway, with R10's feet flat on the floor, and R11 was sleeping in bed. R1's wheelchair wheels nearly ran over R10's toes repeatedly as R1 moved back and forth in R1's wheelchair. R1 then began touching R10's personal items located in an open drawer for several minutes before proceeding further into R10/R11's room to a table containing drinking

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S9999	Continued From page 10 glasses. At 3:53PM, R1 then picked up a drinking glass containing a beverage and drank from the glass, at which time R11 woke from sleep, and stated "No, (R1), no (R1), stop." Facility staff then walked by R10/R11's room and removed R1 from R10/R11's room. On 1/3/2025 at 3:53PM, R6 reported R1 keeps trying to get into everyone's room. On 1/3/2025 at 2:46PM, V5 (Registered Nurse) reported R1 was attempting to intentionally ram R1's wheelchair into R6 on 12/10/2024. On 1/6/2025 at 11:17AM, R8 reported R1 wanders frequently and R8 has had to "throw (R1) out" of R8's room twice recently. (B)	S9999		